TRO NORTH TRICARE PRIME TRAVEL BENEFIT INTAKE FORM

PATIENT INFORMATION				
Patient's Name (last, first, middle):		Patient SSN:		
Patient Status (Check One): ADFM ☐ Retiree ☐ RET FM ☐ Other ☐		Patient DOB (dd/mm/yyyy):		
Gender: Male Female		/ /		
Patient Home #: () -		Patient Work #: () -		
Patient Address:				
City, State, Zip:	Email:			
Sponsor SSN:	Sponsor Status (Check one): Active Duty ☐ Retired ☐	Sponsor DOB (dd/mm/yyyy): / /		
Appt. Date (dd/mm/yyyy):				
		Inpatient Adm Date: / /		
Departure Date (dd/mm/yyyy) Return Date (dd/mm/yyyy) Yes		Care: Yes Discharge Date: / / No Discharge Date: / /		
Estimated Mileage One Way				
Mode of Travel: POV ☐ AIR ☐ Other☐				
NON MEDICAL ATTENDANT (NMA) INFORMATION				
NMA Name (Over age 21):			NMA SSN:	
NMA Status (Check One): Active Duty Active Duty Active Duty F	amily Member 🗌 Retiree 🔲 Ret	tiree Fai	mily Member Non-Family with POA	
Relationship to Patient (parent, spouse, etc)	NMA Dayti	me #: (() -	
NMA Address:				
City, State, Zip:				
PROVIDER (DOCTOR) INFORMATION				
PCM:			PCM Phone: () -	
PCM Address including ZIP code :				
Terradices including ZIF code.				
Specialist Name:	MD Specialty:		Specialist Phone #: () -	
Specialist Address including ZIP Code :				
TRO-North Preauthorization of Car Rental or Air Fare:	By whom		Date	
PRIME TRAVEL	APPROVER (TO BE FILLED	OUT	BY TRO-NORTH)	
TRICARE Prime	Referral/ Authorization		DTOD Mileage one way:	
Approver Initials: Date:			Per Diem Rates	
QUESTIONS? Please contact TRO-North at 703-588-1867 or 703-588-1869 FAX 703-588-0634				
TRICARE Regional Office, ATTN: Prime Travel, 1700 North Moore Street, Suite 1200, Arlington, Virginia 22209 This document may contain information covered under the Privacy Act, 5 USC 522(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions.				